Washington State Employee Assistance Program (EAP)
Contracted Provider Invoice

Do not include any protected health information on this form. This is a billing form and the EAP referral number is required to receive reimbursement.

Provider's Name:

Make Check Payable To:

Mailing Address:

Phone Number:

Provider's EAP Contract Number:

EAP Referral Number (required):

Date of Service	Service Rendered	Time Spent

Provider Signature: _____Credentials: _____ Date: _____

Submit this invoice along with all clinical forms to:
Department of Personnel
Employee Assistance Program
Attn: Contract Manager
701 Dexter Avenue N, Suite 108
Seattle, WA 98109
206-281-6315
Fax 206-281-6319

For internal use only

Fund _____ Program Index _____ Sub Object _____ Amount $_____ (Hours x $60)

Signature Approval _____ Date _____